INSTRUCTIONS

APPLICATION FOR INITIAL LICENSURE AS A NURSE-MIDWIFE

An applicant must submit the following to the Board of Nursing:

1. Application form completed in ink or typewritten, applicant's signature properly notarized, and

2. Fee of $100.00 in the form of U.S. check or money order in U.S. funds, made payable to the Treasurer of the State of Maine (may also pay by Visa or MasterCard) **APPLICATION FEE IS NOT REFUNDABLE**, and

3. Recent passport type photograph (not more than two years old), signed, dated, and enclosed with the application, and

4. Verification of basic nursing licensure from original state of licensure (**If you have a Maine RN license, active or inactive, you do not have to provide this information**), and

5. Verification of certification as a nurse midwife from your national certifying body, and

6. Documentation of enrollment in the Continued Competency Assessment (CCA) or Certificate Maintenance Program (CMP), and

7. Nursing transcript directly from your advanced practice nursing program, and

8. Declaration of Primary Residence form.

It is imperative that you provide your entire name (no initials), including any and all previously used names. If you do not have a middle, maiden, or previous names, than you must write NONE in the appropriate space.

MAINE STATE BOARD OF NURSING
158 State House Station • Augusta, Maine 04333-0158
(207) 287-1133

APPLICATION FOR INITIAL LICENSURE AS A NURSE-MIDWIFE

DO NOT WRITE IN THIS SPACE

Application Received _____

Fee: Cash____Check____CC_____MO__

Receipt No. _____

License Date_____

APRN LICENSE NUMBER_____

Application Approved by Board of Nursing

_____
Chair

_____
Executive Director

_____
Date

SECTION I. PROFILE INFORMATION

Print Legal Name

_____
(first) (middle) (maiden) (last)

List Any Other Names Used Previously

_____

Residential Address_____
(street and number or route)

_____
(city) (state and zip code)

Mailing Address (if different from above)_____

_____
(city) (state and zip code)

If you reside out of the state of Maine, are you on a per diem assignment or is your intention to relocate to Maine? Please explain _____

_____

Telephone number (H)_____(W)_____(CELL)_____

E-mail Address _____Social Security Number_____

Birthplace _____Date of Birth_____
(city/state) (month/day/year)

SECTION II. NURSING EDUCATION

Basic School of Nursing _____
(name)

_____
(street address) (city & state)

Date of Entrance _____ Date of Graduation _____ Length of Program _____

Diploma ☐ Associate ☐ Baccalaureate ☐ Masters ☐ Doctoral ☐ Certificate ☐

Accelerated Masters ☐ (Please provide information regarding previous degree) _____

_____

_____

Advanced Practice School of Nursing _____
(name)

_____
(city & state)

_____ _____
(Accrediting Agency e.g. ACNM) (dates of attendance)

Certificate ☐ Baccalaureate ☐ Masters ☐ Post Masters Certificate ☐ Doctorate ☐

SECTION III. LICENSURE HISTORY

Do you now hold or have you ever held a license to practice nursing (registered or practical) in the State of Maine? Yes ☐ No ☐

If you have been issued a RN license, enter license number and expiration date.

_____ _____
Maine RN License No. Expiration Date

Original registration (**Basic Nursing Licensure**):

State/Country _____ Year _____ License No. _____By Exam Yes ☐ No ☐

List **all** nursing licenses you have ever been issued LPN, RN, and CNM. **Attach additional sheet if necessary.**

State or Country	License No	CNM/RN/LPN	Date of Issue	Date of Expiration

SECTION IV. EMPLOYMENT INFORMATION

A. List employment in nursing for the past five years (attach additional paper if necessary)

Name of Agency	City and State	Dates of Employment	CNM/RN/LPN

B. If you have not been employed in nursing in the past five years, please explain _____

_____

_____

C. Where in Maine do you plan to work? _____
(name of facility/agency)

_____
(street/route no./box no.) (town/city) (zip code)

_____
(contact name) (telephone number) (fax)

SECTION V. NURSE-MIDWIFE CERTIFICATION

A. Are you currently certified as a nurse-midwife by a national certifying body? Yes ☐ No ☐

If YES, indicate the certifying body _____

_____

If NO, indicate name of qualifying examination and date scheduled to test _____

_____

SECTION VI. PHARMACOLOGY AND PRESCRIPTIVE PRACTICE

A. Did you have a course in pharmacology in your nurse-midwife program? Yes ☐ No ☐

IF YES, how many credits and/or contact hours? _____

(45 contact hours/3 credits required)

IF NO, but pharmacology was integrated, please have your program send a letter explaining how integration was accomplished and how much pharmacology was included. Please have your program include information regarding the following in its explanation:

1. Number of contact hours and/or credits (45 contact hours/3 credits required)
2. Applicable state and federal laws
3. Prescriptive writing
4. Drug selection, dosage, and route
5. Information resources
6. Clinical application of pharmacology related to specific scope of practice

IF NO, but you have obtained contact hours or credits in pharmacology in a formal academic setting or non-credit continuing education offerings, please provide certificates and documents that verify the offering covered in the information numbers 1-6 or have your program send official transcripts **directly** to the Board.

B. Have you prescribed in the last two years? Yes ☐ No ☐ New NM Graduate _____

IF YES, please provide documentation from your current/former employer that you prescribed medications in the last two years.

IF NO, please provide the Board with documentation of 15 contact hours of recent (within the last two years) continuing education in pharmacology.

Have you prescribed in the last five years? Yes ☐ No ☐ N/A ☐

IF NO, please provide the Board with documentation of 45 contact hours (3 credits) of recent (within the last two years) continuing education in pharmacology.

SECTION VII. DISCIPLINARY INFORMATION

A. Has any Board of Nursing ever fined, warned, censured, or reprimanded you? Yes ☐ No ☐

B. Have you ever had a nursing license placed on probation, denied, suspended or revoked in any state? Yes ☐ No ☐

C. Is there any complaint pending against your license in any state or jurisdiction? Yes ☐ No ☐

D. Have you ever been disciplined for problems resulting from a physical illness or condition? Yes ☐ No ☐

E. Have you ever been disciplined for problems resulting from mental illness? Yes ☐ No ☐

F. Have you ever been disciplined for problems resulting from chemical dependency? Yes ☐ No ☐

G. Have you ever been convicted of a crime other than minor traffic violations? Yes ☐ No ☐

If you answered "YES" to any of the above questions, indicate all state(s) or jurisdiction(s) involved and attach an explanation.

THIS FORM MUST BE NOTARIZED

TAPE TOP ONLY
one recent photograph

Sign back of photo and indicate year taken

Photo must be:

Full Face View

Passport Type

Clear and recognizable likeness

I, the undersigned, being duly sworn, say that I am the person referred to in this application for licensure in the State of Maine, that the statements contained herein and on all attachments are true and correct in every respect, that I have complied with all requirements of the law, and that I have read and understood this affidavit.

Signature of Applicant _____

Sworn to before me this _____ day of _____, 20_____.

(SEAL) Notary Public _____

My commission expires _____ in and for the State of _____

MAINE STATE BOARD OF NURSING
158 State House Station
Augusta, ME 04333-0158

VERIFICATION OF REGISTERED NURSE LICENSURE

TO _____ Board of Nursing

Name of Applicant _____
First Middle Maiden Last

Present Address _____

License Number _____ Birth Date _____ Social Security Number _____

Information below to be completed by Board of Nursing in your State of original licensure

High School Diploma: Yes _____ No _____ Equivalency _____

Nursing Program: Name _____

Location _____

State Accredited: Yes _____ No _____ Length of Program _____

Date of entrance _____ Date of completion _____

Associate degree _____ Baccalaureate degree _____ Diploma _____

License number _____ Date issued _____ Date current license expires _____

Issued on the basis of examination _____ ; endorsement _____ ; waiver _____.

Has license ever been suspended, revoked, probated, reprimanded or limited/restricted? Yes _____ No _____
If yes, please attach explanation.

*Results of State Board Test Pool Examination/NCLEX

Series Number _____

Scores:

*Please indicate if examination was taken more than one time.

Medical Nursing _____

Psychiatric Nursing _____

**If applicant did not write SBTPE/NCLEX, specify type of test and list subjects and grades on back.

Obstetric Nursing _____ NAME _____

Surgical Nursing _____ TITLE _____

Nursing of Children _____ STATE _____

Comprehensive NCLEX _____ DATE _____

Canadian Examinations:

CNATS_____ Provincial _____

Taken in English _____ French _____

(SEAL)

NCSBN Nursys® National Council of State Boards of Nursing

LICENSE VERIFICATION REQUEST FORM

*** NEW *** Want to process your verification faster? Try our new secure Online Verification to process your verification immediately. Go to https:\\www.nursys.com

Please use blue or black ink. *See reverse side for form eligibility and instructions.*

PERSONAL INFORMATION

Social Security Number:	Date of Birth: (mm/dd/yyyy)	
First Name:	Middle Name:	Last Name:
Maiden Name:	Date of Original License (mm/yyyy)	
Street Address:		
City:	State:	Zip/Postal Code:
Country:	Home Phone:	Work Phone:

ENDORSEMENT INFORMATION *List the license types that you need verified*

License Type (check one)		Total Verification Fee
LPN:	☐	$30.00
RN:	☐	$30.00
Both LPN & RN:	☐	$60.00

Fees are not refundable

The only acceptable forms of payment are
CERTIFIED CHECK, CASHIER'S CHECK,
or MONEY ORDER.

Made payable to: NCSBN
DO NOT SEND cash, personal checks, business checks, or travelers checks.

LICENSE INFORMATION *List all licenses that you have ever held*

	Jurisdiction/State	RN License Number	PN License Number
Original			
Additional			
Additional			
Additional			

States applying to: _____

_____

I, the above named individual, hereby apply for verification to the National Council of State Boards of Nursing to permit NCSBN and/or its Member Boards to verify my licensure, educational, disciplinary, and related information in Nursys® for the purposes of supporting my request for endorsement verification in the jurisdiction(s) listed above and any other states in which I have ever been licensed. I also confirm that the information I have submitted is true.

My application fee of $_____ in guaranteed funds is attached.

Mail this form to:
National Council of State Boards of Nursing, Inc.
35331 Eagle Way
Chicago, IL 60678-1353
DO NOT SEND THIS FORM TO YOUR BOARD OF NURSING

Signature _____ Date _____

Revised February 06, 2006

\Nursys\Forms\20060206LicenseVerReqForm.doc

NCSBN Nursys®
National Council of State Boards of Nursing

FORM INSTRUCTIONS

1. Only boards of nursing within the United States have access to Nursys®. If you need verification of a license for a foreign country or to an agency other than a state board of nursing, please contact your state board of nursing.
2. You **MUST CONTACT** the state where you are seeking licensure to determine which state(s) they require verification from, as boards of nursing have different requirements.

   If you do not need verification of a license from one of the states listed below, **DO NOT** complete this form. Instead, follow the verification instructions of the state where you are seeking licensure. Complete this form **ONLY** if the state where you are seeking licensure requires verification from one of the states listed below.

Alaska (AK)	Kentucky (KY)	New Hampshire (NH)	Tennessee (TN)
Arizona (AZ)	Maine (ME)	New Jersey (NJ)	Texas (TX)
Arkansas (AR)	Maryland (MD)	New Mexico (NM)	Utah (UT)
Colorado (CO)	Massachusetts (MA)	North Carolina (NC)	Vermont (VT)
Delaware (DE)	Minnesota (MN)	North Dakota (ND)	Virginia (VA)
Florida (FL)	Mississippi (MS)	Ohio (OH)	West Virginia - PN (WV)
Idaho (ID)	Missouri (MO)	Oregon (OR)	Wisconsin (WI)
Indiana (IN)	Montana (MT)	South Carolina (SC)	
Iowa (IA)	Nebraska (NE)	South Dakota (SD)	

3. Please complete all sections of this form. Forms with missing information or incorrect payments will be returned. **SEND ONLY THIS FORM AND PAYMENT. ALL OTHER FORMS ARE UNACCEPTABLE.**
4. **PAYMENT:** To verify RN licenses, the total fee is $30, regardless of how many states you are licensed in or how many states you are applying to. To verify LPN licenses, the total fee is $30, regardless of how many states you are licensed in or how many states you are applying to. To verify both RN and LPN licenses, the total fee is $60, regardless of how many states you are licensed in or how many states you are applying to.

   All payments must be in guaranteed funds. **The only acceptable forms of payment are: certified checks, cashiers checks, or money orders** – made payable to the **NCSBN**. DO NOT SEND cash, personal checks, business checks, credit cards, or traveler's checks. **Fees are non-refundable.**

5. Please complete this form in blue or black ink. Print or type clearly. Illegible forms will be returned.
6. Verifications are entered into Nursys® in the order in which they are received at NCSBN. **The verification report will remain in Nursys® for 90 days, after which it expires.** When the Board of Nursing receives your Endorsement Application, the board will access Nursys® to verify any licenses held in the states listed in number 2 above. No paper reports are sent from NCSBN.
7. **EXPIRED REPORTS:** If your verification has expired, you must pay an additional $30 and submit a new verification request form to NCSBN.
8. Nursys® information is updated from the participating nursing boards listed in number 2 above. A nurse who recently received a license may have to wait until the next update before the information is available in Nursys® for license verification.
9. If you have questions regarding this form, please contact the Nursys® License Verification Department at (312) 525-3780 or toll free (866) 819-1700.

*** NEW *** Want to process your verification faster? Try our new secure Online Verification to process your verification immediately. Go to **https:\\www.nursys.com**

STATE OF MAINE
BOARD OF NURSING
158 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0158

JOHN ELIAS BALDACCI
GOVERNOR

MYRA A. BROADWAY, J.D., M.S., R.N.
EXECUTIVE DIRECTOR

DECLARATION OF PRIMARY STATE OF RESIDENCE

Name:_____ **Social Security Number**_____

Permanent/Residential Address:

_____
(Apartment #, RR#, Street)

_____
(City, State, and Zip Code)

Mailing address: (If same as above check here _____)

_____
(PO Box, Apartment #, RR#, Street)

_____
(City, State, and Zip Code)

Telephone Number_____ **Email address:**_____

( ) Yes ( ) No Are you currently employed in the U.S. Military (Active Duty) or the U.S. Federal Government?

In accordance with Chapter 11 Regulations Relating to the Nurse Licensure Compact Part II, 2.a. of the Nurse Licensure Compact Rules and Regulations, I declare that the State of_____ is my primary state of residence and is my legal state of residence.

I affirm that the contents of this document are true and correct to the best of my knowledge and belief. Providing false or misleading information may result in disciplinary action by the Board.

_____ _____
(Signature) **(Date)**

_____
(Print Name)